STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING _____ B. WING _____	R 06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure survey completed on 5/2/12, which resulted in an immediate jeopardy. Survey dates: June 12 and June 13, 2012 Facility number: 000226 Provider number: 155333 AIM Number: 100267730 Survey Team: Terri Walters, RN-TC Martha Saull, RN Carole McDaniel, RN (6/12/12) Dorothy Watts, RN (6/12/12) Census bed type: SNF: 14 SNF/NF: 86 Total: 100 Census Payor type: Medicare: 27 Medicaid: 63 Other: 10 Total: 100 Sample: 11 Paoli Health and Living Community was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Quality review completed on June 14, 2012 by Bev Faulkner, RN	{F 000}		